

CHAPTER 14

SECTION 4

EVALUATION

1.0. PREPAYMENT/PRE-ENCOUNTER SCREENS, AUDITS AND EDITS

On a quarterly basis, contractors shall evaluate the efficiency of the prepayment/pre-encounter review systems by reviewing those situations and cases where significant losses occurred due to fraudulent practices which could have been prevented by a safeguard in the system of prepayment or internal controls. The findings and proposed remedial action shall be reported to the Contracting Officer in an effort to prevent future losses. The design and application of prepayment/pre-encounter screens shall be accomplished with consideration that claims processing/treatment are not unnecessarily delayed.

2.0. POSTPAYMENT

The contractor must have written procedures for postpayment utilization review procedures and the reports produced. The contractor shall devise and implement utilization control screens to identify beneficiaries who may be receiving unnecessary services or services at an inappropriate level of care; e.g., repeated hospital admissions, frequent office visits, care provided by multiple providers, etc., or who may not be receiving medically necessary services under managed care. The contractor shall develop a written analysis of services provided by high volume institutional providers. The contractor shall develop a written analysis of services provided by high volume professional and outpatient institutional providers. The procedures shall include review of current and archived claims history (includes present and prior contractor data) and criteria for referring cases to professional review. The contractor shall maintain documentation of the action taken on each provider or beneficiary identified with a potential aberrancy by the postpayment utilization reports, including the rationale for the decision. The contractor shall analyze the reports on each provider/beneficiary identified by the postpayment system to determine whether potential fraud or abuse exists.

NOTE: High Volume beneficiaries are those beneficiaries whose charges exceed \$50,000 during a 12 month reporting period. High volume providers are institutional providers whose payments exceeded \$750,000; individual providers whose payments exceeded \$50,000, Groups/Clinics whose payments exceeded \$100,000 (over \$25,000 average per professional provider within the group.)

3.0. SIGNATURE RELAXATION PROGRAM AUDIT

3.1. The contractor's randomly selected, statistically valid postpayment audit requirement shall be used to verify provider compliance with the requirements for beneficiary or other authorized beneficiary representative signature on file. (See [Chapter 8, Section 5, paragraph 6.0.](#))

3.2. If there is some indication that there is potential fraud or abuse, the contractor shall follow the fraud and abuse procedures as specified in [Chapter 14, Section 2](#).

4.0. PROVIDER SIGNATURE AUTHORIZATION-ON-FILE IRREGULARITIES

4.1. The contractor shall verify facsimile or representative signature authorizations in accordance with [Chapter 8, Section 4, paragraph 3.2](#).

4.2. If there is some indication that there is potential fraud or abuse, the contractor shall follow the fraud and abuse procedures as specified in [Chapter 14, Section 2](#).

5.0. PROBLEM PROVIDER CASES

5.1. On occasion, the efforts to correct a problem provider through the educational efforts of contractor provider relations personnel and contacts by professional peers will have little or no apparent effect. Such cases should be carefully reviewed by the contractor's medical director and/or other peer advisors. If, in the opinion of the contractor's medical director or advisor, the problem poses a threat to the welfare of beneficiaries or a significant problem in utilization of services, the contractor, with concurrence of the contractor's medical director or advisor, should take the following action:

5.1.1. For contracted providers, the contractor should review its agreement with the provider for compliance and take appropriate action, which may include canceling the agreement.

5.1.2. For all providers, the contractor shall refer the case to the TMA Program Integrity Office with the following information:

- A summary of the issues;
- A description of how the problem was identified;
- A description of efforts made by the contractor to resolve the issues and why they were not successful;
- A description of actions taken, including whether the provider has been placed on 100% review;
- A copy of all relevant claims, EOBs, and correspondence and other contact records,
- A provider history for the most recent 24 month period in either magnetic disk and/or hard copy form, and
- Any other relevant information (congressional interest, threat of legal action, appeals currently in progress, etc.).

5.1.3. In cases involving potential patient harm, contractors shall individually notify those patients (or their parents or guardians if underage 18 or incapacitated) who are affected.

